

LACTULOSE (enulose)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext and options _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY**

CRITERIA:

- ▶ **DOCUMENTED** Chronic liver failure, Hepatic encephalopathy, Chronic portal hypertension, or Spina bifida.

INFORMATION:

- ▶ 6000 ml or less per month does not need a prior authorization.
- ▶ More than 6000 ml's per month requires an authorization.
- ▶ This drug is **not** approved for use as a general laxative over 6000 ml's.

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy.

